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ABSTRACT

A review was conducted of literature published over the past 15 years pertaining to attachment factors associated with the formation of anorexia and bulimia nervosa. This review first aims to shed light on the connections between disruption in attachment and psychological disturbances underlying eating disorders. The second purpose is to encourage further exploration of the etiology of eating disorders as related to attachment with the hope that additional studies will help in the treatment and prevention of their occurrence. The review is divided into two parts. Part 1 provides definitions of the constructs examined and explains the theoretical formation on which the research is based. Part 2 addresses methodological considerations crucial to the examination of the scope of the research presented. Although there is an association between attachment functions and eating disorder pathology, the literature does little to advance an understanding of how disturbances in development of secure attachment relate to subsequent manifestation of symptoms of eating disorders. Ideas are advanced on what research is necessary to illuminate perspective or developmental course of eating disorders. (Contains 76 references.) (JDM)

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THE RELATIONSHIP BETWEEN ATTACHMENT AND EATING DISORDERS: A REVIEW OF THE LITERATURE

by

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THE RELATIONSHIP BETWEEN ATTACHMENT AND EATING DISORDERS: A REVIEW OF THE LITERATURE

A Doctoral Research Paper

Presented to

The Faculty of the Rosemead School of Psychology

Biola University

In Partial Fulfillment

Of the Requirements for the Degree

Doctor of Psychology

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by

Robin Marie Lewis

December, 2000

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ABSTRACT

THE RELATIONSHIP BETWEEN ATTACHMENT AND EATING DISORDERS:

A REVIEW OF THE LITERATURE

by

Robin Marie Lewis

This paper presents a review of pertinent literature published over the past 15 years that pertains to attachment factors associated with the formation of Anorexia and Bulimia Nervosa. Attachment theorists claim that secure attachment is a necessary component for the development of healthy adolescence and adulthood. There is clinical evidence for the presence of attachment disturbances in anorexic and bulimic populations. However, empirical research to date suggests that specific factors associated with attachment theory have not yet been clearly identified as contributors to the development of eating disorders. Therefore, the aim of this literature review is twofold. The first purpose of the review is to present current theories that may shed light on the connection between disruptions in attachment and the psychological disturbances underlying Anorexia and Bulimia Nervosa. However, few inferences about the role of attachment process in the etiology and maintenance of eating disorders can be drawn from existing literature. Therefore, the second purpose of the review is to encourage further exploration of the etiology and maintenance of eating disorders as related to attachment, with the hope that more focused and reliable studies will ultimately aid in the treatment and prevention of Anorexia and Bulimia Nervosa.

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THE RELATIONSHIP BETWEEN ATTACHMENT AND EATING DISORDERS: A REVIEW OF THE LITERATURE

Introduction

Although references to Anorexia Nervosa date back several centuries (Casper, 1983; Parry-Jones & Parry-Jones, 1991), it was only in the late 1960s that a diagnostic definition of the disorder was formulated. Binge-purging behavior has been referenced in documents dating back to the Roman Empire. However, Bulimia Nervosa was only first described in detail as a distinct diagnostic entity in 1979. Since the late 1960s, literature regarding the understanding and treatment of Anorexia and Bulimia Nervosa has expanded considerably, progressing toward second and third generational studies. Currently there is a general consensus among researchers that drug therapies and psychotherapies are more effective than placebo or minimal treatment control therapies (Jimerson, Herzog, & Bartman, 1993; Mitchell & Zwaan, 1993). Currently, studies comparing the active treatments for the disorders are being performed to evaluate their degree of efficacy. Additionally, initial efforts have been made to link outcomes to predictors and/or mediational variables (Charnock, 1989; Polivy & Herman, 1993). Several studies focus on individuals who fail to respond to an initial treatment (Craighead & Agras, 1991; Walsh, Hadigan, Devlin, Gladis, & Roose, 1991). The initial treatment is viewed as a crucial aspect in the treatment of eating disorders because data indicate that,

even when treated with the more effective approaches, many patients are not successfully treated with the first intervention. Overall, there is a low treatment success rate with eating disorders (Blundell & Hill, 1993).

The purpose of the following paper is to focus on one variable that might inform treatment: attachment styles of persons with eating disorders. This paper will provide an overview of theoretical formulations that propose connections between attachment and the complex behavioral and psychological problems involved in eating disorders. The literature review will then evaluate the current connections of the role disruptions in attachment play in the development of the psychological disturbances underlying Anorexia and Bulimia Nervosa. Finally, a critical evaluation is made of empirical attempts to test hypotheses about the relationships among particular aspects of attachment and eating disorders.

The attachment system is considered influential in a wide range of psychological functions, such as interpersonal competencies, regulation of affect, and maintenance of self-esteem (Kenny & Hart, 1992; Friedberg & Lyddon, 1996). It is the intention of this review to evaluate only the empirical research that studies the contributions of the attachment system to the disturbances found in eating disorders. Thus, the review focuses on theory based studies that have hypothesized and tested associations between attachment disturbances and the psychopathology of eating disorders.

The review is divided into two parts. Part one provides definitions of the constructs that will be examined. Part one also explains the theoretical foundation on which the research, which is presented in part two, is based. This will include a summary of popular theories that have attempted to understand pathology in general, and eating

disorders in particular. Part two begins by addressing the methodological considerations crucial to appropriate examination and understanding of the wide scope of research presented. Also presented are the research data, as well as problems encountered in the studies. Part two concludes with a synopsis of the literature review.

Part I

Definition of Terms

An effective literature review requires a substantial comprehension of the constructs presented; therefore, to provide a clear understanding of the literature presented, the two main constructs being studied, attachment and eating disorders, will be defined. Unfortunately, defining the constructs measured is not an easy task, and there is not a clear consensus regarding the definitions reviewed. In regard to attachment, researchers have varied in their classification of attachment styles, yet many of these classifications often coincide or overlap. Similarly, in regard to eating disorders, the criteria and definition of an anorexic or bulimic differ substantially among research studies. For example, although some researchers used the complete Diagnostic and Statistical Manual of Mental Disorders (4th ed. [DSM-IV]; APA, 1994) criteria to determine whether or not an individual had an eating disorder, other researchers only used parts of criteria when they attempted to make the same determination. This makes it difficult to compare the different research findings, as the constructs are somewhat obscured.

Researchers' frequent interchange of terms, that nonetheless retain the same implied definition, is another complication encountered when reviewing the literature. For example, in the literature on Anorexia Nervosa, the terms Anoretic and Anorexic are both commonly used to describe a person who suffers from Anorexia Nervosa. In the following review, these terms will be used interchangeably. Also, the term eating disorder will be used to refer to both Anorexia and Bulimia Nervosa. Additionally, to provide a measure of consistency, the definitions of mental disorders given below are based on the Diagnostic and Statistical Manual of Mental Disorders (4th ed., Text Revision; [DSM-IV-TR], APA, 2000).

Attachment Theory

Attachment refers to a set of contact seeking behaviors that serve to maintain closeness between one person and another. These behaviors, according to infant researchers, are developed as patterns that can be observed between the mother-child diad in infancy (Burge et al., 1997). Further, Burge, et al. (1997) found that early maternal attachment representations tend to stabilize over time as internal working models and may influence the quality of later attachment experiences.

Bowlby's attachment system. The "attachment system," set forth by John Bowlby in 1973, involves a major, biologically adaptive motivational complex. The term "attachment" in this theory denotes a very specific relationship characterized by a person's use of another individual as a source of security. When a person is anxious or fearful, his or her attachment system activates behaviors intended to secure proximity to the attachment figure, who can then function as a calming agent (Bowlby, 1973). It is important to note that Bowlby makes a clear distinction between attachment and other

motivators of social bonding. According to Bowlby, the motivation behind attachment behavior involves the search for a calming agent that serves as a means of reducing stimuli to a tolerable level. Other motivators of social bonding, such as affiliation, sexuality, and play, involve the search for arousal. The latter are viewed as distinct and independent behavior systems. For Bowlby, the ability and desire to depend on someone in time of stress is a fundamental human quality that endures over the life span and is associated with healthy functioning.

From the perspective of Bowlby's theory a variety of psychiatric problems stem from disturbances in the attachment system. Of particular interest is the phenomenon of "anxious attachment," characterized by chronic separation distress. This syndrome is fueled by assumptions, based on experience, that attachment figures are fragile, frustrating, or unpredictable people who will be inaccessible or insensitive when called upon for support. In view of its implications for the understanding of eating disorders, it is important to note that anxious attachment has a variety of psychological consequences, most notably, phobias, low self-reliance, and susceptibility to separation depression (Bowlby, 1973).

Attachment styles. Attachment behaviors may be classified as indicating whether one is securely, avoidantly, or ambivalently attached. Infants classified as securely attached protest the mother's departure, actively seek her out, and are comforted upon her return. They also use the mother as a secure base from which to explore the surrounding environment. Avoidant infants have the appearance of being self-reliant and they display gaze aversion, apparent detachment from their mothers, and little distress over separation. Some researchers have found that mothers of avoidant infants are distinctly averse to

physical contact with their babies and range from emotionally cool to overtly rejecting (Armstrong & Roth, 1989). Ambivalently attached babies have been described as those who protest loudly at their mothers' departure, but also resist attempts to be consoled on her return (Salzman, 1997). They are easily frustrated and show diffuse anxiety, even in the mothers' presence.

Eating Disorders

The DSM-IV-TR describes eating disorders as severe disturbances in eating behavior. The DSM-IV-TR includes two specific diagnoses, Anorexia Nervosa and Bulimia Nervosa. Throughout the paper, the term eating disorders is used to mean both Anorexia Nervosa and Bulimia Nervosa, unless otherwise specified. This grouping of the two disorders is based on several research studies suggesting that differences in perceived parental bonding between anoretic and bulimic subjects seem to be mainly structural. Anoretic as well as bulimic subjects do not make a distinction between the perception of the relationships they have with their mothers and fathers (Sordelli, Fossati, Devoti, La Viola, & Maffei, 1996). Anoretic and bulimic subjects perceived their parents as statistically equally rejecting (Humphrey, 1986), and equally deficient in parental empathy (Palmer, Oppenheimer, & Marshall, 1988; Steiger, Van der Feen, Goldstein, & Leicher, 1989). The only noteworthy difference appears to be that the bulimics view their parents as both caring and overwhelming, contrasting with the anorexics' perceptions of their parents as absolutely caring (Sordelli et al., 1996).

Anorexia Nervosa. Anorexia Nervosa is characterized by a refusal to maintain a minimally normal body weight. Central to the anoretic is the fear of gaining weight, with the accompanying misperception that one is grotesquely fat, even in the presence of

indisputable evidence to the contrary (APA, 2000). The DSM-IV-TR diagnostic criteria for Anorexia Nervosa include the following: a refusal to maintain body weight at or above a minimally normal weight for age and height; an intense fear of becoming fate; disturbance in the way one's body weight or shape is experienced; and in post menarcheal females the absence of at least three consecutive menstrual cycles. Specific types of Anoreia Nervosa are restricting and binge-eating/purging. Restricting anorexics will not regularly engage in binge-eating or purging behavior. The binge-eating/purging anorexic regularly engages in binge-eating or purging behaviors.

Bulimia Nervosa. Bulimia Nervosa is characterized by repeated episodes of binge eating followed by inappropriate compensatory behaviors. Bulimics usually have an awareness that the eating pattern is abnormal and fear not being able to stop eating voluntarily. Bulimia Nervosa involves recurrent episodes of binge eating characterized by a discrete period of time, and a sense of lack of control over eating during the episode (APA, 2000). The specific criteria set by the DSM-IV-TR include the following: recurrent inappropriate compensatory behavior in order to avoid weight gain; binge eating and compensatory behaviors on average at least twice a week for 3 months; and self-evaluation that is unduly influenced by body shape and weight. Additionally, the disturbance does not occur during episodes of Anorexia Nervosa.

The specific types of Bulimia Nervosa include purging and non-purging. The purging bulimic regularly engages in self-induced vomiting or the misuse of laxatives, diuretics, or enemas. The non-purging bulimic uses other inappropriate compensatory behaviors, such as fasting or excessive exercise, but does not regularly engage in self-induced vomiting or the misuse of laxatives or diuretics.

The Etiology of Eating Disorders

Over the past several decades, three frameworks, including family systems theory, psychoanalytic theory, and attachment theory, have most often been utilized to conceptualize Anorexia and Bulimia Nervosa. Theorists have identified two main factors believed to contribute to the development of these complex disorders. These factors are family dynamics and the mother-infant dyad relationship. Research has generally focused on various developmental routes leading to the disorders, and attachment theory not only plays a vital role in understanding the disorders from a developmental point of view but also provides a foundation for its application at a cognitive level.

Family systems theory and psychoanalytic theory will be briefly discussed in order to elucidate how the factors identified are hypothesized to contribute to the development of eating disorders. Researchers implementing the family systems theory have focused on the dynamics of the family as a unit; those employing psychoanalytic theory have examined the mother-daughter relationship and the intrapsychic conflict of the daughter. Attachment researchers have pointed to the need for protection and security involved in child-parent relationships. An emphasis will be placed on the role of attachment theory in the etiology of Anorexia and Bulimia Nervosa in order to distinguish more clearly the unique features of the theory.

Family Systems Theory

Family systems theory is a based on an understanding of the individual in light of the family system in which he or she was raised. Based on the belief that the interactions of members in dysfunctional families are different from those of normal families, Minuchin, Rosman, and Baker (1978) developed a model of what they termed

"psychosomatic families." They hypothesized that psychosomatic families are characterized by four interactive behaviors: enmeshment, rigidity, over protectiveness, and conflict avoidance. Enmeshment is described as the absence of boundaries among family members in daily functioning. Rigidity refers to the existence of inflexible boundaries that are maintained regardless of the specifics of a situation and to the point that family members' well being is jeopardized. Families characterized as conflict avoidant have a tendency to minimize issues so as to avoid real or perceived conflict.

Various studies (Armstrong & Roth, 1989; Connors, Johnson, & Stuckey, 1984; Tucker & McNamara, 1995) have investigated differences in the behaviors and atmosphere of eating disordered versus non-eating disordered families. In general, an eating disordered patient perceives her family as lacking cohesion and expressiveness, enjoying fewer recreational activities, and being more conflicted (Johnson & Flach, 1985; Ordman & Kirschenbaum, 1986). Also evidenced is a strong expectation of achievement, despite little emphasis being placed on intellectual and cultural endeavors. Johnson and Flach (1985) contend that, for a bulimic individual a double bind occurs in which he or she is expected to achieve at a high level while being encouraged to remain enmeshed in a family that does not encourage self-sufficient or expressive behavior that might facilitate successful achievement.

Psychoanalytic Theory

According to psychoanalytic theory, the mother is instrumental in providing a holding environment and empathic care during the first years of an infant's life (Humphrey & Stern, 1988). An infant who feels secure and that her needs have been met will depart from the mother and engage in activities away from her. Feeling secure

enough to move away from the mother will ultimately result in healthy separation and individuation. Psychoanalytic theory stipulates that a mother who is intrusive, overprotective, or indifferent to her child's emotional and physical needs fails to contribute to the development of an adequate ego structure in the child (Humphrey & Stern, 1988). A strong ego structure is necessary because it contributes to a sense of body identity that enables one to distinguish between biological and emotional needs. Similarly, strong ego structure contributes to the child's learning to deal with the tasks of autonomy and self-regulation, as well as how to monitor internal body states, including hunger and satiety (Humphrey, 1988).

As the pubescent girl's body changes and the emotional and social demands from the environment change, she may face newfound confusion and helplessness (Friedlander & Siegel, 1990). This time can also be difficult for the child's mother, who may have unresolved issues of separation and loss with her own mother. If the mother-daughter relationship is especially close, the mother may unconsciously refuse to let the daughter go, thus impeding the separation-individuation process whereby the daughter develops a distinct identity of her own. Separation difficulties create a foundation for psychopathology, and thus the potential for an eating disorder increases.

Theorists suggest that eating disorders are more likely to occur in families that have been preoccupied with physical appearance and/or food for two or more generations (Armstrong & Roth, 1989; Hart & Kenny, 1997). In these families, food becomes a concrete symbol of the maternal object. The daughter is able to act out ambivalent feelings with both her actual and her internalized mother by controlling her food intake. In terms of Bulimia Nervosa, the binge serves to control the needed object and relieves

inner rage and tension (Becker, Bell, & Billington, 1987). According to Beattie (1988), giving into the regressive wish to binge is then negated and punished through purging, which itself can give vent to aggression and provide emotional release. This binge-purge cycle has been described by Humphrey (1998) as a metaphor for the pervasive and chronic deficits and excesses that exist in the family as a whole: The bulimic craves food, but all family members long for and solicit nurture, care, and empathy from one another.

Attachment Theory

Recently, there has been growing dissatisfaction with the family systems and psychoanalytic models that emphasize individuation. At the same time there has been an increasing interest in the role that parental connection plays in psychological functioning and adult development (Barmrid, 1991). Family systems theory and psychoanalytic models include aspects of parental connection. However, it is attachment theory that addresses the increasing interest in the function of parental attachment.

Within the conceptual framework of attachment theory, the attachment relationship is differentiated from other relationships by its primary function, which is protection. According to the model, the foundation of attachment is behavioral and/or psychological proximity, and its set goal is subjective "felt security" (Cicchetti, Cummings, Greenberg, & Marvin, 1990). Attachment styles develop in response to the interplay between the infant's attempts to maintain proximity to the attachment figure in times of threat and the accessibility and responsiveness of the attachment figure.

The main characteristics of the attachment system include functionally defined behavioral, cognitive, and affective responses to the perceived unavailability of the attachment figure; its elicitation by threat; its specificity to particular attachment objects;

and its persistence. The attachment system that a child develops informs and affects the particular aspects of relatedness. Additionally, the attachment system interacts with other behavioral systems that also affect the individual's interactions with the world (Bowlby, 1980). Therefore, psychological development, including the freedom for exploration, depends on the security of attachment. Optimal development occurs in the context of secure attachment relationships.

These descriptions of attachment originally arose out of Bowlby's (1953), Ainsworth's (1963), and Robertson's (1953) observations of infants separated from their mothers. Subsequently, most of the empirical work arising from attachment theory has focused on individual differences in patterns of attachment in infancy and early childhood assessed through observation of responses to threats to attachment, primarily separation from parents (Ainsworth, Blehar, Waters, & Wall, 1978). A fundamental difference has been identified between attachment patterns classified as secure and insecure. According to attachment theory, secure attachment arises when infants develop, through experiences of appropriate parental responsiveness, an expectation that the parent will be available and that they, the children, are worthy of care (Dozier, 1990). In times of threat, the securely attached infant actively seeks closeness to the caregiver in order to reduce distressing affect, and the infant actively greets the parent upon reunion. When not feeling a threat, the securely attached infant is able to interact confidently with the world. Insecure attachment occurs when the child's expectation of a parent's availability and the child's personal self worth fail to develop because of perceived inaccessibility or inappropriate responsiveness of the care giver. In times of threat, an insecurely attached infant minimizes the importance of the parent's absence, and fails to seek closeness at

reunion or display separation distress (Ainsworth et al., 1978). The term insecure avoidant is used to describe the minimizing of the parent's absence, and the avoidance of parents upon return. In some cases, an insecurely attached infant may become hypervigilant to the caregiver's ability and may then become extremely and easily distressed, and difficult to soothe at reunion. This type of reaction is known as an insecure-ambivalent or resistant attachment (Ainsworth et al., 1978). Main and Solomon (1990) have identified a third type of insecure attachment characterized by mixed, disorganized, and disoriented responses to separation and reunion.

Attachment is rooted in behaviorism (Bowlby, 1980); however, it has always been presented as a psychological theory to describe certain aspects of interpersonal relationships that are represented intrapsychically. Such theorizing links attachment research to psychodynamic formulations, particularly object relations theory. But attachment concepts, such as Bowlby's notion of "working models," are also compatible with recent attempts within empirical psychology (Baldwin, 1992) to understand from a cognitive, affective, and behavioral point of view the internalized (i.e., cognitive) structures and functions that organize attachment relationships and behaviors. Working models of attachment at a cognitive level include memories of attachment-related experiences; beliefs, attitudes, and expectations about the self and other in relation to attachment; attachment goals and needs; and plans and strategies to achieve these goals and satisfy these needs. The move to "the level of representations" has facilitated the application of observed individual differences in infant separation and reunion behaviors to attachment in older children, adolescents, and adults.

Besides these general applications, there is also an expanding literature on attachment in "special" populations, identified as groups of individuals whose pathology affects attachment functions. The premise of these applications of attachment theory to psychopathology in adults and adolescents is that the behavioral, cognitive, and affective features of the attachment system are central to the progress toward adaptive functioning and personality formation. These features of the attachment system influence the development of beliefs and competencies with respect to interpersonal functioning. The beliefs and competencies influence an individual's sense of self, self-efficacy, and self-esteem, as well as his or her capacity to regulate affective life and motivation.

Whereas secure attachment is associated with healthy functioning, insecure attachment is related to psychopathology and dysfunction. According to attachment theorists, many psychiatric disorders can be attributed to, or are related to, disturbances in attachment patterns between individuals and primary caretakers (Bowlby, 1973). Unlike other theories, attachment theory is not based on the assumption that psychopathology results from fixation in or regression to an early stage of development (Bowlby, 1980; Guidiano & Liotti, 1983). Rather, attachment theorists contend that psychopathology can occur at any age and happens when a person's psychological development takes an unnatural path (Bowlby, 1980; Burge et al., 1997; Guidiano & Liotti, 1983). These theorist argue that when an individual's needs have not been adequately or consistently met, psychological development will take a deviant route, and the world will be perceived as unpredictable and cause a response of shrinking from or doing battle with it (Bowlby, 1973).

The legacy of insecure attachments includes not only the risk of significant impairments in these areas of functioning, but also the possibility of profound disruption or delay in the individual's psychological development through "sensitive periods" (Cicchetti, 1993). This may be particularly so for those periods that demand changes in attachment relationships. Clearly, adolescence, with its emphasis on separation from the parents and on gaining independence, is a key sensitive period for the attachment systems (Holmbeck & Hill, 1986). Considering that the majority of eating disorder cases have their onset in adolescence, it may be that the group of symptoms that define eating disorders may be one manifestation of the maladaptive negotiation of adolescence (Striegel-Moore, 1993) and the disruption of the attachment process in that stage of development.

Guidiano and Liotti (1983) conceptualized various psychopathologies, including eating disorders, using attachment theory. They suggest that the parent-child relationship is extremely complex and that the child's perceptions are the primary cause of problems in relating. Therefore, according to Guidiano and Liotti, if the child constructs the world and the attachment relationship as unsatisfying, he or she will be put at a disadvantage and be less able to cope with adverse experiences later in life.

Attachment and Eating Disorders: Relational Patterns

Several decades ago, theorists began advocating that attachment disruption plays a central role in the pathogenesis of eating disorders. Bruch (1973), Palazzoli (1978), and Masterson (1977) were the most influential in this area. Bruch (1973) challenged the prevailing psychodynamic views of Anorexia Nervosa by suggesting that the ego deficits

and libidinal inhibitions observed in anorexics were not due to oedipal conflicts. Rather, she postulated that the ego deficits were consequences of a long-term, disturbance in mother-daughter interactions, with the onset of disturbance occurring at an earlier, pre-oedipal stage of development. Similarly, Palazzoli (1978) described a pathological relationship between the child and an intrusive, emotionally unresponsive, and demanding mother, who was consequently internalized as a controlling function within the child. Masterson (1977) gives an account of the anoretic during early mothering as having been rewarded for dependency, as well as discouraged or emotionally "punished" at signs of separation or independence. The outcome for the child is an overwhelming fear of abandonment and confusion during adolescence when she attempts to separate or individuate.

Despite their differences in emphasis, all of these accounts of the etiology of Anorexia Nervosa link specific disturbances in early infant-mother relationships to disturbances encountered during the child's attempts at autonomy in adolescence. According to the theorists, these specific disturbances in attachment may result in the obsessive pursuit of thinness, in an over controlled attempt to maintain a prepubescent body (Masterson, 1977; Palazzoli, 1978). These theorists' ideas converge to identify this pathological phenomenon as the core of Anorexia Nervosa.

Theories about the nature of impaired developmental processes in Bulimia Nervosa are more recent; they also emphasize the possibility that inappropriate parental involvement results in the child's failure to adequately separate both physically and cognitively from the maternal object (Sugarman & Kurash, 1982). Drawing on Mahler, Pine and Bergman's (1975) theorizing and observations of mother infant interactions,

Sugarman and Kurash (1982) identify the early practicing sub-phase of the separation-individuation process as critical for the development of healthy body differentiation to take place successfully. If this sub-phase is jeopardized by the mother through inaccurate responsiveness to the infant, it leads to a hostile, or at best ambivalent, connection between the infant and her own bodily functions, as well as an incomplete or tenuous separation from the mother. During adolescence the flood of bodily changes, together with the demands for greater physical and psychological autonomy, results in the return of these hostile-ambivalent feelings, which are rooted in the "beliefs" that have been internalized at a sensorimotor, presymbolic level. In this model, binge eating allows the bulimic a way of maintaining an attachment to the mother via a sensorimotor representation, that is, the activity of eating.

The aforementioned formulations regarding the development and maintenance of eating disorders focus on the failure to develop a "sense of autonomy." In Anorexia Nervosa, the pursuit of thinness is a protection against the intrapsychic and psychosocial demand that the adolescent alter her attachment relationships and become more independent of parental figures. In terms of attachment theory, the development of autonomy equals freedom to explore the physical and social environment and is predicated on the secure base of attachment relations and internalization of a sense of security. The hypothesized over intrusiveness and protectiveness of the mother of the anoretic do not allow the infant to develop adaptive self-competencies to tolerate the distress and anxiety associated with any threat of separation.

In the case of Bulimia Nervosa, the formulations predicate the disorder on insecure attachment, with binge eating viewed as a regressive attempt to maintain a sense

of connection and therefore to escape from the anxiety associated with separation. The psychological features of binge eating, namely the loss of control and volition that accompanies the frantic consumption of food, could be viewed in attachment terms as the reflection of the uncontrollable distress connected with separation for the insecure-resistant type of attachment.

Part II

Methodological Considerations

Before reviewing research results, it is necessary to discuss concerns regarding research in general and also to consider the methodology employed by the researchers, especially in regard to the criteria used to create treatment populations. Research in any field of study often enthusiastically reports findings when they are positive and minimizes findings when they are negative. Therefore, often an illusion "fact" is created when studies are brought together, interfering with the accuracy of the overall conclusions that may be drawn in a literature review. Additionally, multiple studies may claim to measure the same construct, yet the criteria used to define a construct often vary, ultimately leaving the constructs open to interpretation. This complicates researchers' ability to accurately compare the results of different studies.

A specific concern relates to continual revision of diagnostic criteria as they appear in the Diagnostic and Statistical Manual of Mental Disorders (3rd ed. [DSM-III]; APA, 1980). The formal diagnostic system for DSM-III Bulimia appeared in 1980. The criteria were substantially modified for the published DSM-IV. Although many aspects

of the current criteria set are strong, as the diagnostic system has been improved through various revisions, several aspects of the criteria set remain unproved and are perhaps arbitrary. For example, the criterion requiring symptoms of Bulimia Nervosa to be present for 3 months at the frequency of two episodes per week has minimal research backing, but is part of the current DSM-IV criteria. In actuality, most patients who seek treatment binge eat and vomit much more frequently. Also, there are concerns associated with the diagnostic category of Eating Disorder Not Otherwise Specified. There are further questions about the parameters defining "non-purging" bulimia and what constitutes "excessive" in dieting and exercise. In short, as the scientific basis for certain categories of both Anorexia and Bulimia Nervosa continues to be developed, variance among treatment groups must be taken into account when analyzing or comparing studies.

The DSM system has created guidelines for target populations selected for research studies. However, because diagnostic criteria have continually been revised, few of the treatment studies have used identical criteria for defining subject groups. The studies differ not only in DSM criteria changes, but also in what the research studies focus on in regard to the criteria sets. Thus, there are many different criteria sets used to define eating disorder diagnoses in the reviewed articles. Although the differences are often subtle, they usually affect decisions about the inclusion or exclusion of subjects, thus causing variability among the studies.

A further methodological consideration is that the diagnostic groups chosen for research studies tend to represent only a narrow subset of the population of people with disturbed eating patterns. Several studies exclude factors such as age and gender, which

could potentially reduce the reliability of the findings. Diagnostic issues other than those directly concerned with eating behavior must also be examined for relevance to inclusion criteria. For example, Anorexia and Bulimia Nervosa commonly begin in adolescence, yet generally only college aged adult females have been included in treatment studies. Thus, eating disorder literature focuses relatively exclusively on young, educated women. The literature tends to propose theories that relate to adolescence, yet studies tend to be conducted using a relatively older population of women. Empirical knowledge involving older age groups or males with these disorders is sparse.

Attachment and Eating Disorders-Empirical Research

Multiple studies have proven that correlations exist between attachment disruptions and eating disorders (Cole-Dethke & Kobak, 1996; Humphrey, 1986). However, more precise connections between the two have been difficult to identify. Researchers have attempted to identify specific factors related to attachment that may contribute to the formation of eating disorders. There are two sets of literature examining the relationships that exist between the many factors associated with attachment and eating disorder pathology. The larger of these literature sets mainly involves observational, case study material. Often these discussions rely on theoretical argument with occasional appeals to "empirical" observation about the nature of eating disorder patients and their families. Frequently, they illustrate their rhetoric with case examples, with no reference to empirical findings. The other set of literature is smaller in size and attempts to empirically test the nature and extent of the proposed links between attachment disturbances and eating disorders. This latter set of literature, which is often

derivative of clinical literature and psychodynamic formulations, represents what currently is empirically known about the relationships hypothesized to exist between the two constructs. This set of literature is more open to integration and review, and it is this literature that will therefore be presented.

Palmer et al.'s (1988) study of 72 female patients referred to a clinic specializing in eating disorders was the first to address the quality of perceived attachment relationships of women with anorexia (n = 35) or bulimia (n = 37) to their parents. This study used the Parental Bonding Instrument (PBI; Parker, Tupling, & Brown, 1979) to assess perceptions of maternal and paternal care and protection during the first 16 years of childhood. Compared to a standardization sample (Parker, 1983), individuals suffering from anorexia or bulimia reported their mothers to be less caring, that is, less warm, affectionate, and empathic. Only bulimics in the sample described their fathers as less caring. Neither eating disorder group differed from the normative sample in terms of perceived maternal or paternal protection. A similar study (Pole, Waller, Stewart, & Parkin-Feigenbaum, 1988) reported on the PBI responses of 56 bulimics being treated at an outpatient eating disorder clinic and 30 age-matched controls. A significantly lower proportion of the bulimics in the sample described their parenting as "optimal" (high care and low protection); that is, more bulimics perecived their parents to be less caring and overprotective as compared the cotnrol group. However, the results differ slightly from the study done by Parker (1983) in that the data appear to be influenced by a disproportionate number of bulimic patients who viewed their parents as uncaring but not overprotective. Therefore, the studies suggest that perceived differences in maternal care were most powerful in discriminating anorexic and bulimic patients from controls.

Nonetheless, in the study conducted by Pole et al. (1988) there is some evidence to suggest differences in the ways bulimics and contols view their fathers in terms of overprotectiveness.

These initial studies in attachment and eating disorders were partially replicated in a study by Calam, Waller, Slade, and Newton (1990). This study included a group of patients with Anorexia and divided a group of patients with Bulimia into those with and without a history of Anorexia. Ninety-eight eating-disordered women and 242 controls completed the PBI. Maternal and paternal care scores and paternal protection scores reliably discriminated the eating-disorder groups from the controls, particularly the bulimic without a history of anorexia. Thus, both anorexics and bulimics rated their parents as less caring as compared to the control group's ratings. Additionally, both groups, but particularly individuals without a history of anorexia, rated their fathers as more protective as compared to the control group's ratings. Steiger, Van der Feen, Goldstein, and Leicher (1989) also used the PBI together with a measure of eating attitudes (Eating Attitude Test [EAT]; Garner & Garfinkel, 1979) in a comparison of 58 eating-disordered women and 24 noneating-disordered women matched for age and socioeconomic status. The eating-disordered group was subtyped into restrictive anorexics, bulimic anorexics, bulimic with a history of anorexia, and bulimic without a history of anorexia. On the PBI measures, there were significant differences between the groups on paternal care and protection. The eating-disordered group as a whole rated their fathers as less caring than the noneating-disordered women; the significant paternal protection difference was accounted for by perceived paternal overprotectiveness on the part of the bulimic anorexics.

Sordelli et al. (1996) had slightly different findings in a study conducted on 42 anoretic subjects and 26 bulimic subjects. The study focused on significant differences as described by the PBI between anoretic and bulimic subjects. The analysis revealed the presence of significant qualitative differences in PBI profiles in the bulimics' view of their parents as both caring and overwhelming, in contrast to the anoretics' perception of their parents as caring but not overwhelming.

Another study (Rhodes & Kroger, 1992) used the PBI with an eating-disordered sample to assess aspects of attachment dynamics. It compared 20 women with a diagnosis of anorexia (n = 11) or bulimia (n = 9) with 20 aged-matched noneating-disordered women. The analysis revealed no significant differences on the PBI paternal measures. However, this study also used the Separation-Individuation Test of Adolescence (Levine, Green, & Millon, 1986), which revealed significant differences between the eating disordered and control groups on its scales of Separation Anxiety, Engulfment Anxiety, Dependency Denial, and Healthy Separation. The eating disordered groups measured higher on the pathological traits and lower on healthy separation when compared to the control groups.

The arguments connecting data obtained by the PBI and predictions about eating disorder pathology based on attachment theory are often unclear (Steiger et al., 1989), or specious (Palmer et al., 1988; Rhodes & Kroger, 1992). However, Armstrong and Roth (1989) provide a well-argued, rational basis for associating attachment style, particularly anxious attachment and separation distress, to the pathology of eating-disordered women. In an attempt to test these associations empirically, they evaluated the responses of 27 hospitalized women with a primary diagnosis of anorexia nervosa (n = 12), bulimia

nervosa (n = 12), and atypical eating disorder (n = 4) to the separation situations depicted in the Adolescence Separation Anxiety Test (SAT; Hansburg, 1986). Comparison data on the SAT for noneating-disordered samples were provided by earlier research on identity formation (Rhodes & Kroger, 1992) and intimacy (Levitz-Jones & Orlofsky, 1985). The results of the study indicated that 96% of the eating disordered women displayed anxious attachments and 85% showed extreme separation depression. Additionally, when compared with women dealing with issues of identity formation and intimacy, the eating disordered women showed excessive dysfunctional reactions to separation. No difference on the SAT measure were found between the anorexic and bulimic groups. Tentative support for these observations, specifically regarding the insecurity of attachment in bulimics is provided in a study by Bell, Billington, and Becker (1986). They used a self-report bulimia inventory to classify 547 volunteer college women into four groups: purging bulimic (n = 16), restricting bulimic (n = 40), problem eaters (n = 183), and non-problem eaters (n = 308). The groups differed on the Insecure Attachment subscale of the Bell Object Relations Inventory (Bell et al., 1986), with both bulimic groups reporting greater fear of abandonment and lack of autonomy in relationships as compared to the other women. In addition, 48% of the purging bulimic group reported pathological levels of insecurity in relationships compared to 32% of the restricting bulimic group, 28% of the problem eaters, and 17% of the non-problem eaters, suggesting that purging bulimics are the most insecure in their relationships, and a significant proportion of restricting bulimics and problem eaters also experience pathological insecurity in relationships. The groups did not differ on the Alienation, Egocentricity, or Social Incompetence subscales of the Bell Object Relations Inventory.

Although some of these authors (Armstrong & Roth, 1989) recognize that dysfunctions in attachment may be functionally related to specific disturbances of eating or weight control behavior and that a thorough understanding will require an examination of particular links between attachment dysfunction and the symptoms of eating disorders, they do not extend their study to supply relevant data. However, the following three studies do provide pertinent information regarding symptoms of attachment dysfunction and symptoms of eating disorders.

Heesacker and Neimeyer (1990) examined the relationships among the following constructs: eating disorder pathology, measured by the Eating Disorder Inventory (EDI; Garner, 1983) and the EAT (Garner & Garfinkel, 1979); object relation function, using the Bell Object Relations Inventory as an index of attachment; and aspects of relational schema, assessed by a repertory grid technique. Their sample consisted of 183 young college women who volunteered to take part in a study of eating attitudes and interpersonal relationships. The researchers used multiple regression analysis to estimate the contribution of object relation measures and the cognitive structure of relationships to scores on the Drive For Thinness subscale of the EDI and total score on the EAT. The results indicated that higher levels of self-reported eating disturbances were related to a stronger drive for thinness. The cognitive structure most strongly linked to eating disturbance was characterized by restriction, inflexibility, and tightly organized interpersonal schemas. Using similar correlational methodology, Kenny and Hart (1992) examined the relationships among the three scales of the Parental Attachment Questionnaire (PAQ; Kenny, 1990) and the eating disorder "symptoms" measured by the EDI. Sixty-eight female inpatients with a diagnosis of bulimia ($\underline{n}$ = 50) or anorexia

(n = 18) and 162 college women served as subjects. The eating disordered group scored significantly lower than the college group on the PAQ measures of Affective Quality of Attachment, Parental Fostering of Autonomy, and Parental Role in Providing Emotional Support. In addition, the perceived affective quality of attachment to the parents and the degree to which the parents were judged to promote autonomy were negatively associated with feelings of personal ineffectiveness, preoccupation with thinness, and high levels of bulimic behavior. In a large corelational study, Lavik, Clausen, and Pedersen (1991) administered the PBI, EAT-12 and the 12-item General Health Questionnaire (GHQ) to a cohort of 1,193 adolescents aged 13-18, including 631 females. For this sample of adolescent females, maternal care correlated negatively (r = -.14) with the Oral Control Factor of the EAT-12, and maternal and paternal protection correlated positively (r = .14; r = .20) with the Oral Control Factor.

Several studies have been published reporting the relationship between attachment strategies or styles and symptom reporting. A recent longitudinal study by Burge et al. (1997) investigated the relationship of attachment cognitions, current psychological functioning, and psychological functioning 12 months later. Attachment cognitions were assessed with the Revised Adult Attachment Scale and the Inventory of Parent and Peer Attachment. The study was based on 137 women who completed a 1-year-follow-up after original testing. The researchers found that attachment cognitions were significantly associated with current symptomatology. In the area of eating disorders, symptomatology was predicted by attachment cognitions about parents, peers, and romantic partners. However, no clear pattern emerged to provide more specific associations between particular attachment cognitions and eating disorders.

A similar study by Cole-Dethke and Kobak (1996) attempted to measure the relationship between attachment strategies and symptom reporting. Using the Adult Attachment Interview, information provided by the transcripts was rated by using the Attachment Interview Q-Sort on 61 women who reported high or low levels of depressive and eating disorder symptoms. The symptoms were classified as strategies in which one focuses on the subjective depressive features (hyperactivating) or the eating disorder behavior (deactivating). The results indicated that women with hyperactivating AAI strategies were prone to reporting elevated levels of depression symptoms, whereas women with deactivating strategies were prone to reporting elevated levels of eating disorder symptom when depression was statistically controlled. The study supports the hypothesis that secondary or defensive attachment strategies predispose individuals toward different forms of symptom expression (Cole-Dethke & Kobak, 1996). The study failed to find any statistically significant relationships between specific symptoms that presented. This raises the possibility that attachment strategies are not equivalent to psychopathology but rather act as potentiating factors in a developmental pathway model for the emergence of symptoms.

The data reviewed support the hypothesis that attachment disturbances are evident in women with eating disorders. They suggest that anxious, insecure attachments, fear of abandonment, and difficulties with autonomy differentiate young women with eating disorders from their noneating disordered contemporaries. In addition, eating disordered women's beliefs about the affective quality of their attachment to their parents and their perception of their parents' support for autonomy have been linked to specific features of their eating disorders. These associations are consistent with the theoretical links

between parentally imposed obstacles to the development of secure attachment and autonomy and key aspects of eating disordered pathology (Cole-Dethke & Kobak, 1996). However, the putative link between maternal intrusiveness and overprotectivness and the symptoms of eating disorders was generally not supported when measured by eliciting memories of paternal care and protection (PBI). Indeed, eating disordered women, particularly those showing bulimic features, more often recall their fathers than their mothers as overprotective. In this regard, the conclusion of Palmer et al. (1988) in the earliest study, appear to be appropriate despite additional data that has been obtained. Their results revealed incompatibility with the theoretical prediction that an intrusive, overprotective quality of parenting is more likely to be associated with the development of eating disorders.

Analysis of Research Problems and Prospectives

Despite the evidence of attachment disturbances in eating disordered women, and correlations between these disturbances and key features of eating disorders, conclusions about their role in the development of the psychological and behavioral pathologies characteristic of eating disorders are limited by the significant methodological shortcoming of the studies. The most striking obstacle to drawing meaningful inferences from the studies is the lack of appropriate comparison groups. None of the studies used another psychologically disturbed group or utilized controls for concurrent psychological dysfunction in order to strengthen inferences about the specific connections between attachment disturbances and eating disorder pathology. In particular, the competing hypotheses that the observed attachment difficulties are related to the elevated levels of

depression or interpersonal anxiety frequently observed in eating disordered samples (O'Kearney, Gertler, Conti, & Duff, 1995) are routinely disregarded by all the studies cited. In addition, the studies make no attempt in their selection of appropriate control groups to limit the confound of the possible relationship between attachment measures and problematic aspects of eating behavior commonly observed in noneating disordered samples of young women (e.g., dietary restraint and disinhibition).

In addition to these major threats to the internal validity of the studies, there are other sampling problems that significantly limit the strength of inferences about attachment functioning in eating disorders. The developmental focus of attachment theory and emphasis on disruption of attachment with the "sensitive period" of adolescence in the theoretical formulations of eating disorders reviewed suggest that age would be better conceptualized as a covariate rather than controlled by matching or by ignoring it as in most of the studies. The salience of attachment issues and the individual's current psychological mechanisms to deal with these issues are likely to differ in a 14-year old adolescent girl with a recent onset of anorexia and a 24-year old woman with a 7-year history of anorexia. Despite this, the studies investigate group outcomes on the attachment measures by aggregating attachment difficulties across the ages. Similarly, all the studies disregard the nature and quality of current attachment relationships and hence fail to take into consideration the possible mediating effects of these dimensions to the subjects' beliefs about the quality of their parental attachments.

Besides these sampling and design limitations, there are problems related to the measurement of attachment and eating disorder symptoms; these issues will need to be addressed in subsequent empirical work. Lyddon, Bradford, and Nelson (1993) and

Lopez and Gover (1993) have reviewed self-report measures used to assess attachment in adolescence and adulthood. In general, the measures used to assess attachment in the studies reviewed have adequate reliability. Information about the validity of the inventories is variable, with the PBI and Separation-Individuation Test of Adolescence (SITA) showing advantages with regard to concurrent validity and the breadth of their applications (Levine & Saintonge, 1993). The applicability of each of the measures to attachment functioning, however, remains uninvestigated and is unclear. Criticisms of the inventories in terms of their insensitivity to attachment dynamics and their range of sampling of attachment functions can be made. For example, Armstrong and Roth (1989) argue that the SAT provides an index of the long-term emotional effects of the type of parenting disturbances described in the literature for anoretic and bulimic families because it activates "affective memories of mothering and cognitive schemata regarding oneself and one's relationship" (p. 152). In view of the differences in parenting profiles for anoretic and bulimic families which have been described empirically (Strober & Humphrey, 1987), the lack of differential response to the SAT by anorexics and bulimics in their sample suggests problems with the sensitivity of the measure in accessing aspects of these cognitive schemata. In addition, the PBI relies exclusively on memories of attachment-related experiences with parents and fails to assess the full range of attachment beliefs, expectations, goals, and strategies that constitute the cognitive domain of an individual's working model of attachment. Similar criticisms can be directed at the other devices used. The issue of the reactivity of self-report measures of attachment functioning to a current major psychotic disorder is not considered by any of the studies reviewed. In such cases, the concurrent use of self-report measures of attachment and

eating disorder psychopathology increases the likelihood that variance introduced by the method of measurement is significantly contributing to the noted differences between groups.

Although there are other problems with sample selection and the definitions of eating disorder pathology that raise questions about the internal and external validity of many of the studies, it is the overall approach adopted by these empirical studies which is more problematic. Many of the methodological problems arise because the studies conceptualize the process that mediates the "disrupted" development of attachment and eating disorder symptoms on a single pathway model. Despite their "clinical richness," the psychodynamic formulations (Bruch, 1973; Masterson, 1977; Palazzoli, 1978) from which much of the empirical work reviewed is derived, the research disregards many possible causal, moderating, and mediating factors, both concurrent and subsequent to the putative attachment disruption.

Conclusion

As more information has become available to theorists about the developmental course of attachment and the variables that influence the attachment process, researchers have widened their scope of study. More comprehensive and multifactorial models are being utilized to examine the relationships between attachment and subsequent behavioral and psychological dysfunction. Multifactorial models have been used to study conduct problems and aggressive behaviors (Greenberg, Speltz, & DeKlyen, 1993; Sroufe, Egeland, & Kreutzer, 1990; Waters, Posada, Crowell, & Lay, 1993), including some with application to depression in adolescence (Kobak, Sudler, & Gamble, 1991).

To more accurately predict externalizing behavior problems in later childhood and early adolescence, these studies incorporated information about early attachment and utilized data describing temperament, contemporaneous parenting, environmental factors, marital conflict, and later parent-child, family, and peer relationships. After summarizing findings about the association of attachment processes and disruptive behavior problems, Greenberg et al. concluded that "it is unlikely that insecure attachment is either a necessary or sufficient cause of later disruptive disorders" (p. 203). Greenberg et al. (1993) also conclude that "main effect models are of little use" (p. 203) in clarifying the role of attachment functions in children and adolescents with disruptive disorders.

Regrettably, the same conclusion can be drawn from the research reviewed in this paper about the association between attachment functions and eating disorder pathology. Although the research provides evidence for the existence of attachment disturbances in eating disorders and an association between disruptions in attachment and symptoms of eating disorders, the "main effect model" adopted both theoretically and empirically by the majority of authors in the area does little to advance the understanding of how, if at all, disturbances in the development of secure attachment relate to the subsequent manifestation of the symptoms of eating disorders.

What is required for such advancement is research that incorporates various perspectives on the developmental course of eating disorders. There are two broad models for such research. The first model involves the combining of multiple factors such as attachment processes, family functioning, parent-child interaction, marital interaction, peer relationships, and even biobehavioral characteristics of individuals. This model includes the charting of developmental pathways of children and families who

vary on reliable and sensitive measures of these factors and who are at risk of or have eating disorders. The more such models draw from diverse theoretical approaches, the more likely they are to provide inclusive and comprehensive formulations of the pathways leading to eating disturbances.

The second model focuses on the processes through which adolescents' attachment functioning may be involved in current eating disorder psychopathology. This model is used to evaluate the hypotheses derived from attachment theory and research about the psychological processes involved in such functions as affect regulation, regulation of self-esteem, social judgement, and interpersonal competencies and performances in a population that already demonstrates disruption in these functions.

Each of the two approaches outlined above will produce different but complementary information about the developmental processes important in the etiology and maintenance of eating disorders. Together , they are more likely than the approaches adopted to date to provide data on which to base judgement about the value of attachment theory in clarifying an understanding of eating disorder psychopathology. Unfortunately, until such information is available, the only valid judgement that can be made is that any contribution of attachment processes to eating disorder pathology is unsubstantiated.

The literature reviewed provides evidence for the existence of attachment disturbances in eating disorders and the association of attachment disturbance with symptoms of eating disorders. However, the research does little to advance our understanding of how disturbances in the development of secure attachment relate to the subsequent manifestation of the symptoms of eating disorders. The vast amount of literature on eating disorders points to a forward motion of exploration and research that

might one day provide a full understanding of the etiology and maintenance of the pathology. It is hopeful that as the eating disorder literature expands, promising treatment regimes will be developed that will provide hope and healing for those who struggle with the complex disorders of Anorexia and Bulimia Nervosa.

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